

**DOUGLAS COUNTY YOUTH SERVICES
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Regarding

Last Name: _____	First Name: _____	Middle: _____	Date of Birth: _____
Other names known by: _____			Social Security #: _____

I (We) _____ authorize the following information to be disclosed as indicated below.

PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED:

Information to be released from:	Information to be released to:
<input type="checkbox"/> Douglas County Youth Services: <input type="checkbox"/> The Department of Social and Rehabilitation Services (SRS): <input type="checkbox"/> School District: USD # _____ <input type="checkbox"/> Medical practitioner, clinic, center or facility: _____ <input type="checkbox"/> Mental health practitioner, clinic, center of facility: _____ <input type="checkbox"/> Social Service agency or provider: _____ <input type="checkbox"/> Employer _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Douglas County Youth Services: <input type="checkbox"/> The Department of Social and Rehabilitation Services (SRS): <input type="checkbox"/> School District: USD # _____ <input type="checkbox"/> Medical practitioner, clinic, center or facility: _____ <input type="checkbox"/> Mental health practitioner, clinic, center of facility: _____ <input type="checkbox"/> Social Service agency or provider: _____ <input type="checkbox"/> Employer _____ <input type="checkbox"/> Other: _____

Information to be released: (PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED)

- All information necessary to provide services
- Academic, achievement or aptitude evaluations and recommendations
- Social, behavioral, psychological, mental or medical histories and evaluations
- Diagnostic and treatment progress and prognoses
- Results of previous treatment
- Drug test results
- Other (specify): _____

The purpose or reason for the release is: (Optional. If no purpose stated, all lawful purposes are assumed)

Read before signing:

I understand that the information which I have authorized to be disclosed will be used for the purpose (s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved.

Client _____ Date _____

Parent/ Guardian _____ Date _____

DCYS Officer _____

This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it. This consent expires upon (date): _____

Signature of person(s) giving consent: _____ Date: _____

_____ Date: _____

Relationship to person whose information is being released: _____